Supreme Court, U.S.
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No. 01-1789

In The
Supreme Court of the United States

PENNSYLVANIA PHARMACISTS ASSOCIATION, BELL EDGE PHARMACY, BROAD STREET APOTHECARY *et al.*,

Petitioners

v.

FEATHER O. HOUSTOUN,

Respondent

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF FOR THE RESPONDENT IN OPPOSITION

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QUESTION PRESENTED

Whether the court of appeals correctly held that Section 1902(a)(30)(A) of the Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A), confers no individual right on Medicaid providers to a particular payment rate that is enforceable under 42 U.S.C. § 1983 because the text and structure of the statute contain no rights-creating language and so reveal no intent to benefit providers.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
TABLE OF AUTHORITIES	iii
STATEMENT OF THE CASE	1
REASONS FOR DENYING THE PETITION	8
I. The Decision of the *En Banc* Third Circuit Is Entirely Consistent with the Precedents of This Court	9
II. The Only Other Court of Appeals That Has Considered the Same Issue Since *Blessing* Is in Accord	13
III. This Case Is an Inappropriate Vehicle for Plenary Review	18
CONCLUSION	20

TABLE OF AUTHORITIES

Page

CASES

Alexander v. Sandoval, 532 U.S. 275 (2001) 14

American Soc'y of Consultant Pharmacists v. Garner, 180 F. Supp. 2d 953 (N.D. Ill. 2001).....16-17, 18

Arkansas Medical Soc'y v. Reynolds, 6 F.3d 519 (8th Cir. 1993).....15, 17

Blessing v. Freestone, 520 U.S. 329 (1997) .....*passim*

Cannon v. University of Chicago, 441 U.S. 677 (1979).....10, 11

Evergreen Presbyterian Ministries, Inc. v. Hood, 235 F.3d 908 (5th Cir. 2000).....6, 7, 8, 15, 16

Florida Pharmacy Ass'n v. Cook, 17 F. Supp. 2d 1293 (N.D. Fla. 1998).....18

Golden State Transit Corp. v. City of Los Angeles, 493 U.S. 103 (1989).....10

Gonzaga Univ. v. Doe, ___ U.S. ___, 122 S. Ct. 2268 (2002).....*passim*

Methodist Hosps., Inc. v. Sullivan, 91 F.3d 1026 (7th Cir. 1996).....15, 17, 18

Moody Emergency Medical Serv. v. City of Millbrook, 967 F. Supp. 488 (M.D. Ala. 1997) 18

Orthopaedic Hosp. v. Belshe, 103 F.3d 1491 (9th Cir. 1997), *cert. denied*, 522 U.S. 1044 (1998).....14

Prestera Ctr. for Mental Health Servs. v. Lawton, 111 F. Supp. 2d 768 (S.D. W. Va. 2000).....18

TABLE OF AUTHORITIES – Continued

Page

Rite Aid of Pennsylvania, Inc. v. Houstoun, 171 F.3d 842 (3d Cir. 1999) 6, 18

South Camden Citizens in Action v. New Jersey DEP, 274 F.3d 771 (3d Cir. 2001), *cert. denied*, 70 U.S.L.W. 3788 (U.S. June 24, 2002) (No. 01-1547) 14

Suter v. Artist M., 503 U.S. 347 (1992) 15, 16

Visiting Nurse Ass'n v. Bullen, 93 F.3d 997 (1st Cir. 1996), *cert. denied*, 519 U.S. 1114 (1997) 15, 16, 17, 18

Walgreen Co. v. Hood, 275 F.3d 475 (5th Cir. 2001), *cert. denied*, 70 U.S.L.W. 3789 (U.S. June 24, 2002) (No. 01-1427) 10, 15, 16

Wilder v. Virginia Hosp. Ass'n, 496 U.S. 498 (1990) ..... *passim*

Wright v. Roanoke Redev. & Hous. Auth., 479 U.S. 418 (1987) 10

STATUTES

Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4711, 111 Stat. 251, 507-08 7

Boren Amendment, Pub. L. No. 96-499, § 962(a), 94 Stat. 2599, 2650 (1980); Pub. L. No. 97-35, § 2173, 95 Stat. 357, 808 (1981) 7, 8, 11, 12, 13, 15, 16, 17

Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396v 1, 14, 16

42 U.S.C. § 1396a(a)(13)(A) 7

42 U.S.C. § 1396a(a)(30)(A) ..... *passim*

42 U.S.C. § 1320a-2 16

42 U.S.C. § 1983 ..... *passim*

TABLE OF AUTHORITIES – Continued

Page

REGULATIONS

42 C.F.R. §§ 447.300-.304 2

42 C.F.R. §§ 447.331-.334 2

BRIEF FOR THE RESPONDENT IN OPPOSITION

Feather O. Houstoun, Secretary of the Pennsylvania Department of Public Welfare, respectfully requests that this Court deny the petition for a writ of certiorari seeking review of the judgment of the United States Court of Appeals for the Third Circuit in this case.

STATEMENT OF THE CASE

Although denial of the petition for a writ of certiorari ("Petition") does not depend on factual matters, the Respondent presents a statement of the case to apprise the Court of facts omitted from the Petitioners' Statement of the Case.

1. The Medicaid Program, established by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396v, is a cooperative Federal-State program under which needy individuals obtain access to medically necessary services. States that elect to participate in Medicaid must submit a "plan for medical assistance," detailing the nature and scope of the State's Medicaid Program, to the Secretary of the United States Department of Health and Human Services ("HHS") in order to qualify for matching federal funds. Among other statutory requirements, a State Plan must

> provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care

> and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. § 1396a(a)(30)(A) ("Section 30(A)").

HHS has not adopted regulations requiring States to implement any particular methodology or rate-making procedures for services covered under their State plans. Nor has HHS prescribed what level of payment will assure that payments for any particular service are consistent with "efficiency, economy and quality of care" and are "sufficient to enlist enough providers." HHS has, however, adopted regulations that establish upper limits governing payments for services, including payments for brand-name and generic drugs. *See* 42 C.F.R. §§ 447.300-.304, .331-.334. Subject to the upper payment limits, HHS leaves to the States how best to achieve the desired outcome of providing access by Medicaid recipients to quality health care services equal to that of the general population at the best possible price.

2. In February 1997, Pennsylvania established a Medicaid managed care program ("HealthChoices") pursuant to a waiver granted by HHS. In HealthChoices, approximately 440,000 Medicaid recipients who reside in the city of Philadelphia and four contiguous counties are enrolled in one of the four health maintenance organizations ("HMOs") under contract with the Department of Public Welfare ("Department"), the State Medicaid agency. The HMOs arrange for the provision of a wide array of health care services, including pharmacy services. Petitioner pharmacies voluntarily chose to participate in HealthChoices to provide pharmacy services to eligible Medicaid recipients.

3. In December 1999, the Pennsylvania Pharmacists Association and sixteen pharmacies – the Petitioners here – joined by no Medicaid recipients, filed suit against the Respondent in the United States District Court for the Eastern District of Pennsylvania. Seeking declaratory and injunctive relief, they alleged that the payment rates offered by the HealthChoices HMOs for prescription drugs and dispensing fees did not reimburse pharmacies for the costs of acquiring and dispensing drugs and, for that reason, did not meet the requirements of Section 30(A). The Respondent filed a motion to dismiss, arguing in part that the Petitioners do not have a cause of action under 42 U.S.C. § 1983 to challenge the pharmacy payment rates as inconsistent with Section 30(A). Believing itself bound by an earlier decision of a panel of the Third Circuit, the district court concluded that the Petitioners have a private right to enforce Section 30(A) under Section 1983 and denied the motion. After extensive discovery, the parties filed cross-motions for summary judgment.

4. In June 2000, the district court granted the Respondent's Motion for Summary Judgment and denied the Petitioners' Motion for Summary Judgment. In accordance with controlling case law in the circuit, the district court considered both the process by which the disputed pharmacy payment rates were implemented and the substantive validity of the rates themselves. Reviewing the process the Department used to establish the payment rates for compliance with Section 30(A), the court found that from the inception of HealthChoices, the Department had applied an access standard, developed with input from the public and approved by HHS, to determine whether recipients had access to pharmacy services. Petition Appendix ("Pet. App.") at 75a. The standard required each

HMO to have at least two pharmacies available to every HMO member within thirty minutes travel time in urban areas and sixty minutes travel time in rural areas. *Id.* at 75a-76a. The court also found, contrary to the assertions by the Petitioners (*see* Pet. at 4), that the Department "continued to consider access when the HealthChoices HMOs lowered their pharmacy reimbursement rates in 1998 and 1999. [The Department] regularly receives lists of providers and maps showing provider access from the four HMOs." Pet. App. at 76a.

The court found, and the Petitioners did not contest, that every pharmacy participating in HealthChoices must be licensed and must comply with applicable state and federal quality and safety standards. It concluded that the Department did not arbitrarily rely on compliance with those requirements to assure quality of care. *Id.* at 77a. The court also determined that the Department did not act arbitrarily in relying on price surveys and analyses that compared the payment rates offered by the HMOs to those of other third-party payors. *Id.* at 78a. According to the district court, these facts established that the Department had not acted arbitrarily and capriciously in allowing the HMOs to set the challenged payment rates. *Id.*

Upon deciding that the Department's process for evaluating the HMOs' rate-setting practices was rational, the court examined whether the Department met the substantive commands of Section 30(A). In considering the actual nature of those commands, the district court rejected the Petitioners' claim that it must consider the "efficiency" and "economy" of the payment rates separate and apart from whether the rates were sufficient to assure that Medicaid recipients have access to services. *Id.* at 78a-81a. Instead, the district court concluded, the crux of

compliance with Section 30(A) is access by recipients to quality pharmacy services at economical and efficient rates. *Id.* at 81a & n.9.

The Petitioners contended in the district court that 50% of the pharmacies that had participated in the Medicaid Program in January 1997 had left the Medicaid Program because they were dissatisfied with the payments. *See id.* at 31a (Becker, J., dissenting). After considering the evidence presented, the district court rejected this contention, finding that as of February 1997, 1,192 pharmacies participated in the pre-HealthChoices (fee-for-service) program, compared to approximately 800 to 900 pharmacies participating in HealthChoices as of April 1, 2000. Pet. App. at 84a n.13, 85a. The court also considered the Petitioners' claim that no pharmacies participated in the HealthChoices Program in certain rural areas in two counties, consisting of approximately fifteen contiguous zip codes, *see id.* at 31a (Becker, J., dissenting), and concluded the claim was unsupported. For the two operating pharmacies in rural Bucks County, the court explained, the Petitioners had failed to show whether those pharmacies participated in any managed care plan network and why they did not participate in HealthChoices. The court then found that in one of those two counties, which was "of greatest concern for the Plaintiffs," 92% of the members of the largest HealthChoices HMO lived within three miles of a HealthChoices pharmacy and 98% lived within five miles. In rural Chester County, those numbers were 66% and 89%, respectively. Pet. App. at 87a-88a.

Based on the evidence presented, the court concluded that the Petitioners had failed to establish a "substantive"

violation of Section 30(A) and entered summary judgment for the Department. *Id.* at 88a.

5. Before the United States Court of Appeals for the Third Circuit, a three-judge panel heard argument on April 20, 2001, where the Respondent urged affirmance on the alternative ground that Medicaid providers may not assert a Section 30(A) claim under 42 U.S.C. § 1983. Before issuing a decision, the court ordered rehearing *en banc*, having concluded that another panel might have held that providers do have an enforceable right under Section 30(A). *See* Pet. App. at 6a-7a (discussing *Rite Aid of Pennsylvania, Inc. v. Houstoun*, 171 F.3d 842 (3d Cir. 1999)). On March 13, 2002, in a 6-to-5 decision, the court held that Section 30(A) is not intended to benefit Medicaid providers, and thus providers have no claim to assert under Section 1983. Pet. App. at 3a. In so ruling, the court noted its agreement with the analysis of the Fifth Circuit in *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908, 928-29 (5th Cir. 2000). Pet. App. at 27a.

Applying this Court's rulings in *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498 (1990); and *Blessing v. Freestone*, 520 U.S. 329 (1997), the *en banc* majority began and ended its analysis with the narrow focus of determining whether the text of Section 30(A) evinces a clear congressional intent to benefit Medicaid providers. In analyzing the text and structure of Section 30(A), the court reasoned that the statute requires states to be efficient and economical in paying for services (that is, by avoiding payments that are too high) and focused on Medicaid recipients by requiring access to quality services. Pet. App. at 13a-14a. The court thus concluded that Section 30(A) was not phrased in terms benefiting health care providers. *Id.* at 14a.

The court compared and contrasted the text of Section 30(A) with the text of the repealed "Boren Amendment" (relating to payments for inpatient hospital and long-term care facility services), which the Court in *Wilder* held did confer a right to "reasonable and adequate" payment rates on providers. *See* 496 U.S. at 524.[1] As did the Fifth Circuit in *Evergreen*, the Third Circuit identified the sharp contrast between the Boren Amendment's specific requirement that States develop payment rates that were "reasonable and adequate to meet the *costs* which must be incurred by efficiently and economically operated facilities" (emphasis added), with the general requirement in Section 30(A) that provider payments be set at levels sufficient to enlist enough providers to meet Medicaid recipients' needs. Reasoning that the plain meaning of "efficiency" and "economy" was "obviously not intended to benefit providers," Pet. App. at 14a, the court noted that Section 30(A) does not command that payment rates be sufficient to cover provider costs. The court of appeals explained that unlike the Boren Amendment, which measured sufficiency of payments with reference to provider costs, Section 30(A) measures adequacy of payments in relation to recipients' health care needs and thus reflects an intent to benefit recipients, not providers. *Id.* at 14a-15a.

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[1] The Boren Amendment, Pub. L. No. 96-499, § 962(a), 94 Stat. 2599, 2650 (1980); Pub. L. No. 97-35, § 2173, 95 Stat. 357, 808 (1981), *previously codified at* 42 U.S.C. §1396a(a)(13)(A), was repealed in the Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4711, 111 Stat. 251, 507-08.

The principal dissent acknowledged the textual differences between Section 30(A) and the Boren Amendment but concluded that the differences were "immaterial" and emphasized instead what it considered to be the "rationale" of *Wilder*, requiring states to establish a "scheme for provider reimbursement," and inferred the existence of a similar scheme from Section 30(A). *Id.* at 29a-30a. According to the principal dissent, its interpretation was supported by "the dynamic of the real world of healthcare," a dynamic that the dissent accused the majority opinion, "short on 'realpolitik'" as it was, of not properly taking into account. *Id.* at 30a. The principal dissent otherwise disagreed with the majority's view that this Court has required that a right may only be created by a statute drafted with "'an unmistakable focus on the benefitted class,'" *id.* at 39a-40a n.1 (citation omitted); concluded that *Wilder* controlled the outcome, *id.* at 40a, 64a; concurred with the decisions of those courts of appeals, issued before *Blessing*, that relied on *Wilder* in identifying an enforceable right, *id.* at 36a-39a; and, finally, flatly disagreed with the Fifth Circuit's decision in *Evergreen* and its "reliance on *Blessing* in concluding that Section 30(A) creates only a system-wide guarantee [to access], not an individual entitlement on the part of providers." *Id.* at 59a.

REASONS FOR DENYING THE PETITION

In an opinion that presaged the decision of this Court last month in *Gonzaga University v. Doe*, the *en banc* court of appeals correctly held that Medicaid providers may not assert a claim to higher payment rates based on Section 1902(a)(30)(A), 42 U.S.C. § 1396a(a)(30)(A) – the "equal

access provision" – under 42 U.S.C. § 1983. The decision is entirely consistent with this Court's instruction, including *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498 (1990), and most recently *Gonzaga*, ___ U.S. ___, 122 S. Ct. 2268 (2002). The only other court of appeals that has addressed the issue presented here since this Court's guidance in *Blessing v. Freestone*, 520 U.S. 329 (1997), reached the same result. The additional guidance afforded by the decision in *Gonzaga* one short month ago, as well as other considerations, makes this case a premature and therefore inappropriate vehicle for plenary consideration of the enforceability of another statutory provision enacted under the Spending Clause.

I. The Decision of the *En Banc* Third Circuit Is Entirely Consistent with the Precedents of This Court.

Approximately one month ago, this Court reiterated that private enforcement of spending legislation is the exception to the "typical remedy" of action by the federal government to terminate funding to the States. *Gonzaga*, ___U.S. at ___, 122 S. Ct. at 2273 ("only twice" in last two decades has Court found spending legislation to confer enforceable rights). The decision of the court of appeals is entirely consistent with that rule. Nonetheless, the Petitioners ask this Court to review the enforceability issue yet again, "to address the conflict between the decision of the Court of Appeals . . . in this case" and "the holding of, and reasoning in, *Wilder*." Pet. at 11, 14. Far from conflicting with *Wilder*, the *en banc* majority of the Third Circuit showed scrupulous fidelity to the teachings of this Court, both in explicating the analytical framework and in applying that framework to Section 30(A).

This Court denied an essentially identical petition, presenting the virtually identical question, less than one month ago. *See Walgreen Co. v. Hood*, 275 F.3d 475 (5th Cir. 2001), *cert. denied*, 70 U.S.L.W. 3789 (U.S. June 24, 2002) (No. 01-1427). This case presents no occasion for the Court to reconsider the need to exercise plenary review.

A. Following the reasoning in this Court's earlier decisions, and without the benefit of the clarification recently articulated in *Gonzaga*, the *en banc* court of appeals focused its inquiry of whether Section 30(A) gives rise to a right enforceable by Medicaid providers on whether the statute is intended to benefit providers. Pet. App. at 9a (citing *Blessing*, 520 U.S. at 340; *Wilder*, 496 U.S. at 509; *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 106 (1989); *Wright v. Roanoke Redev. & Hous. Auth.*, 479 U.S. 418, 430 (1987)). The court of appeals heeded this Court's instruction in *Cannon v. University of Chicago*, 441 U.S. 677 (1979), that the answer to that question is found "'by looking to the language of the statute itself.'" The court noted this Court's emphasis on the need for "'right- or duty-creating language'" that is "'phrased in terms of the persons benefited' and . . . 'draft[ed] . . . with an unmistakable focus on the benefited class.'" Pet. App. at 10a (quoting *Cannon*, 441 U.S. at 690 n.13, 691, 692 n.13). In this regard, the court presciently reasoned, the tests that govern consideration of an implied right of action under a statute and a claimed statutory right under Section 1983 both "ask whether the statute at issue was intended to benefit the putative plaintiff." Pet. App. at 11a (citation omitted).

Thus, in establishing the framework for analysis, the court of appeals not only painstakingly adhered to this Court's earlier teachings but anticipated this Court's

recent ruling in *Gonzaga*. There, the Court reemphasized that "it is *rights*, not the broader or vaguer 'benefits' or 'interests' that may be enforced" under Section 1983. ___U.S. at___, 122 S. Ct. at 2275. It at the same time resolved any ambiguity about the test to be applied in determining whether a statute confers an individual right: "[I]f Congress wishes to create new rights enforceable under § 1983, it must do so in clear and unambiguous terms – no less and no more than what is required for Congress to create new rights enforceable under an implied right of action." *Id.* at ___, 122 S. Ct. at 2279.[3]

B. The extent to which the court of appeals adhered to this Court's decision in *Wilder* is likewise evident from the Court's clarification in *Gonzaga*. In concluding that the language of Section 30(A) was distinguishable from the language of the Boren Amendment, at issue in *Wilder*, the majority reasoned that the directives of Section 30(A) are "'draft[ed] ... with an unmistakable focus on'" and "'phrased in terms benefiting' Medicaid recipients," not providers. Pet. App. at 14a (quoting *Cannon*, 441 U.S. at 691; *Wilder*, 496 U.S. at 510). As the court observed, "[i]f Congress had wanted to look after pharmacies, it would hardly have framed Section 30(A) in the terms it chose." Pet. App. at 14a. The "critical differences" in language between the two statutory provisions "convinced" the court that Section 30(A), unlike the Boren Amendment, is not

[3] The explanation of the Chief Justice on this point decisively settled the disagreement between the *en banc* majority and the principal dissent, *see* Pet. App. at 39a-40a n.1, against the position adopted by the dissent.

intended to benefit, and so confers no right on, providers. *Id.* at 20a.

Rather than conflicting with *Wilder*, the court's comparison of the statutory language proceeded directly from the premise that "the inquiry mandated by *Wilder* and *Blessing* . . . calls for us to draw a fine line and to take into account the precise statutory language adopted by Congress." *Id.* Having done so, the *en banc* majority explained why it disagreed with the principal dissent's conclusion that the two statutory provisions "confer nearly identical rights on providers":

> The language in the Boren Amendment focusing on provider costs is telling because it manifests a clear congressional concern for the economic plight of providers and an intent to benefit them. We are convinced that this statutory language was the basis for the *Wilder* Court's statement that the Boren Amendment was 'phrased in terms benefitting' providers. . . . The principal dissent interprets this statement to mean simply that the Boren Amendment 'required states to establish a scheme for provider reimbursement.' . . . But if this interpretation were correct, the Supreme Court's full sentence . . . would say exactly the same thing twice. . . . We therefore disagree with the principal dissent and believe that the reference to phrasing pertains to the Boren Amendment's cost-reimbursement language.
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> * * *
>
> The principal dissent also misinterprets the Boren Amendment as containing a quality-of-care requirement similar to that in Section 30(A). . . . In fact, however, quality of care played

> a decidedly secondary role in the Boren Amendment. Whereas quality of care is a primary benchmark for setting payments in Section 30(A), the Boren Amendment simply provided that reimbursements were to be calculated by reference to the reasonable costs of providers that were operating in compliance with other applicable legal requirements – in the precise language of the Amendment, 'with applicable State and Federal laws, regulations, and quality and safety standards. . . .'

Id. at 15a-18a (citations omitted).

This Court's recent elucidation of the underpinnings of its decision in *Wilder* confirms that the *en banc* majority, not the principal dissent, analyzed the lesson of *Wilder* correctly. As Chief Justice Rehnquist explained, the *Wilder* Court concluded that the Boren Amendment "left no doubt" of congressional intent for private enforcement because it "required states to pay an 'objective' monetary entitlement to individual health care providers." *Gonzaga*, ___ U.S. at ___, 122 S. Ct. at 2274. The court of appeals in this case correctly recognized that such an "objective entitlement" is entirely absent from Section 30(A). Because the court of appeals properly applied both "the holding of, and the reasoning in," *Wilder*, Pet. at 14, its decision does not merit plenary review.

II. The Only Other Court of Appeals That Has Considered the Same Issue Since *Blessing* Is in Accord.

The Petitioners also ask this Court to resolve a "direct," and purportedly "growing," conflict between the Third and Fifth Circuits on the one hand and the First,

Seventh, and Eighth Circuits on the other. Pet. at 7, 10.[3] Such resolution is necessary, they contend, "so that the Medicaid Act will be uniformly applied throughout the United States, and the ability of health care providers to enforce the Medicaid Act and the implementing federal regulations will not vary from region-to-region." *Id.* at 11.

In urging plenary review, the Petitioners overstate not only the practical significance of the conflict but also the potential import of its resolution. The court of appeals did not consider, and therefore this Court is presented with no occasion to review, the ability of providers to enforce "the Medicaid Act" or any "implementing regulations" promulgated under the authority of the Act. Instead, the court's ruling was limited to Section 30(A), one provision of a multi-sectioned statute. As this Court made clear in *Blessing*, each provision of a multi-section statutory scheme such as Title XIX must be considered on its own terms. 520 U.S. at 342, 344-45.[4]

The decision in *Blessing* also dispels any notion of a "growing" conflict. The two courts of appeals that have

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[3] The Petitioners imply that the Ninth Circuit should also be included in the latter group, *see* Pet. at 10, but that court reached the merits of compliance with Section 30(A) without addressing the threshold enforceability issue. *See generally Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), *cert. denied*, 522 U.S. 1044 (1998).

[4] The Petitioners' attempt to graft the enforceability of regulatory rights onto the decision in this case is precluded for the additional reason that this Court has recently established that regulations may not give rise to rights not found in the authorizing statute. *See Alexander v. Sandoval*, 532 U.S. 275, 291 (2001) (implied right of action). *See also South Camden Citizens in Action v. New Jersey DEP*, 274 F.3d 771, 774 (3d Cir. 2001) (§ 1983 action), *cert. denied*, 70 U.S.L.W. 3788 (U.S. June 24, 2002) (No. 01-1547).

addressed the enforceability of Section 30(A) in the five years since *Blessing* was decided – the Third Circuit here and the Fifth Circuit in *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908 (5th Cir. 2000); and *Walgreen Co. v. Hood*, 275 F.3d 475 (5th Cir. 2001), *cert. denied*, 70 U.S.L.W. 3789 (U.S. June 24, 2002) (No. 01-1427) – have reached the same conclusion.

Those courts that held the opposite did so without the benefit of this Court's counsel to avoid a "blanket approach" in analyzing different sections of the same statute. *Blessing*, 520 U.S. at 344. As a result, those courts mistakenly believed that *Wilder* compelled the conclusion that because providers were the beneficiaries of, and so had a right to enforce, one section of Title XIX – the Boren Amendment – providers are the intended beneficiaries of, and so may sue to enforce, another section of Title XIX – Section 30(A). *See Arkansas Medical Soc'y v. Reynolds*, 6 F.3d 519, 525-26 (8th Cir. 1993) (*Wilder* Court having conducted "careful scrutiny" of Title XIX, providers "are beneficiaries for the same reason that providers in *Wilder* were beneficiaries"); *Visiting Nurse Ass'n v. Bullen*, 93 F.3d 997, 1003-04 (1st Cir. 1996) (discussing *Wilder* and citing *Arkansas Medical Society*); *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996) ("*Wilder's* holding binds us" and "[w]e therefore follow *Arkansas Medical Society*").[5]

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[5] Although the Court first established that "each statute must be interpreted by its own terms" in *Suter v. Artist M.*, 503 U.S. 347, 358 n.8 (1992), before *Blessing*, some courts misinterpreted the meaning of the term "statute." *See, e.g., Arkansas Medical Soc'y*, 6 F.3d at 525 (analysis of Section 30(A) "greatly simplified by the *Wilder* opinion,"

(Continued on following page)

Blessing instructs that such a monolithic approach to Title XIX is not only flawed, but erroneous. The two courts that have had the opportunity to learn from that instruction, and so analyzed Section 30(A) on its own terms, have correctly concluded that because of the material differences in the text and structure of the two statutes, providers are not the intended beneficiaries of Section 30(A), notwithstanding this Court's holding that they were the intended beneficiaries of the Boren Amendment. Pet. App. at 14a-20a; *Evergreen*, 235 F.3d at 928-29; *see also Walgreen*, 275 F.3d at 478 (extending reasoning in *Evergreen* to "efficiency, economy, and quality of care" clause of Section 30(A)).

Given the significance of *Blessing* in establishing the analytical point of departure, the law among the courts of appeals cannot accurately be said to be in conflict. Given the uniformity of opinion since *Blessing*, it certainly cannot be characterized as reflecting a "growing conflict."

Even accepting the Petitioners' assertion of conflict, plenary review by this Court would be premature. None of the courts of appeals that construed Section 30(A) to confer an enforceable right on providers has revisited the issue since *Blessing*. Particularly in light of the Court's recent clarification in *Gonzaga*, it is entirely likely that the enforceability issue will again present itself to these same courts. *Cf. American Soc'y of Consulting Pharmacists*

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which also analyzed Title XIX). Other courts were unclear about the authority to attribute to *Suter*, in light of a subsequent congressional amendment, limiting the case to its holding, at 42 U.S.C. § 1320a-2. *See, e.g.*, *Bullen*, 93 F.3d at 1003 n.5 (assuming Congress intended to "resurrect *Wilder* with no *Suter* overlay").

v. Garner, 180 F. Supp. 2d 953, 971-72 (N.D. Ill. 2001) (intervening developments such as repeal of Boren Amendment and decision in *Blessing* "will make for interesting debate if (or more accurately, when) this issue again reaches the Seventh Circuit"). Indeed, even if the reasoning of the courts in *Arkansas Medical Society* and *Bullen* may be read to reflect at least superficial analysis of Section 30(A) independent of the Boren Amendment, *see* Pet. App. at 24a-25a, 26a-27a (discussing *Arkansas Medical Society* and *Bullen*), *Gonzaga* has removed any doubt about the basis for the holding in *Wilder* and so raises serious question about the continued vitality of the holdings in those cases. Finally, as the *en banc* majority in this case pointed out, both the First and the Seventh Circuits did not consider the issue in its broad context but instead rejected only those arguments presented to them. Pet. App. at 25a-27a (discussing *Methodist Hospitals* and *Bullen*).

The combined force of *Blessing* and *Gonzaga* makes it reasonable to expect that when presented with the issue, the courts will reconsider their earlier decisions. Any conflict that exists is thus of no practical effect. Because of the likelihood that the purported conflict will in any event resolve itself upon additional consideration by the courts of appeals, plenary review by this Court at this time is unwarranted.[6]

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[6] Nor is this Court's review needed to avoid the dire consequences the Petitioners predict. In the ten cases cited in the Petition as evidence of provider litigation "limit[ing] the ability of states to unfairly manipulate Medicaid reimbursement," Pet. at 8-9 (citing cases), two had nothing to do with reimbursement rates and were dismissed on motion

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III. This Case Is an Inappropriate Vehicle for Plenary Review.

Other reasons counsel against plenary review of this case. Although the district court entered summary judgment on the merits in favor of the Respondent, the court of appeals appropriately limited its ruling to the threshold issue and did not address whether the district court applied the correct standard in measuring compliance with Section 30(A). The *en banc* court did not consider, for example, whether Section 30(A) requires a process as well as a result, *compare Rite Aid*, 171 F.3d at 851-53, *with Methodist Hosps.*, 91 F.3d at 1030, or whether the district court properly assessed "substantive" compliance. *See* Pet. App. at 74a-75a, 80a-81a & n.9. These statutory issues overlap with the threshold enforceability issues. Both sets of issues implicate questions such as whether the statute is phrased in "rights-creating language" and the degree of flexibility States should have in administering their Medicaid programs. As the court of appeals wrote, Section

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in whole or in part in any event. *See Prestera Ctr. for Mental Health Servs. v. Lawton*, 111 F. Supp. 2d 768 (S.D. W. Va. 2000); *Moody Emergency Medical Serv. v. City of Millbrook*, 967 F. Supp. 488 (M.D. Ala. 1997). Of the remaining cases, plaintiffs prevailed either on threshold issues or on the merits in only three instances. *See Rite Aid of Pennsylvania, Inc. v. Houstoun*, 171 F.3d 842, 857-58 (3d Cir. 1999) (judgment for plaintiffs vacated and case remanded for further proceedings); *Bullen*, 93 F.3d at 1011 (same); *Methodist Hosps.*, 91 F.3d at 1030 (judgment for defendants affirmed); *American Soc'y of Consultant Pharmacists*, 180 F. Supp. 2d at 977 (preliminary injunction denied for failure to show likelihood of success on merits); *Florida Pharmacy Ass'n v. Cook*, 17 F. Supp. 2d 1293, 1302-03 (N.D. Fla. 1998) (motion to dismiss granted). The outcome in these cases undermines the specter of States run amok without provider-driven litigation to keep them in line.

30(A) "is 'phrased in terms benefitting' recipients, and the adequacy of payments is measured in relation to the health needs of recipient." Pet. App. at 14a-15a.

Neither the question of whether Section 30(A) confers a right on recipients nor the standard for determining compliance with Section 30(A) is, however, presented in this case. No Medicaid recipient is a plaintiff; and, as noted, the court of appeals did not address the merits. Given the many issues raised by a consideration of Section 30(A), only one of which is available for review in this case, it would be appropriate for this Court to defer plenary consideration until a case presents both the combined threshold question of whether providers or recipients have an enforceable right under Section 1983 and the merits questions under Section 30(A).

CONCLUSION

For the reasons set forth above, the petition for a writ of certiorari should be denied.

Respectfully submitted,

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